LEAVE OF ABSENCE

(MRMHA-F)

1a. Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Mental Health Act 2009—Section 34, 36, 37, 38

1b. PERSON ADDRESS DETAILS *(if not on or different from patient label above)*

Address: .....

Suburb/town: ..... Postcode: ___ ___ ___ ___

2. TYPE OF LEAVE OF ABSENCE and PURPOSE

I have examined the above named person and consider it appropriate to authorise a leave of absence for:

☐ A single occasion of leave, or

☐ Recurring occasions of leave over a period of time.

For the purpose of: .....

.....

.....

.....

3. LEAVE DETAILS

Leave is granted from:

Date: __ __ /__ __ / 20 __ __ Time: __ __ : __ __ (24-hour clock)

to:

Date: __ __ /__ __ / 20 __ __ Time: __ __ : __ __ (24-hour clock)

With: ..... At: .....

Duration: ..... Frequency: .....

Other Information: .....

*Note: A single occasion of leave must not be longer than **7 days**.*

Note: This form is valid for a single occasion of leave or for recurring occasions of leave for a period of up to 3 months, after which a new leave of absence must be made.

Leave is granted subject to the following conditions: .....

.....

.....

.....

4. DIRECTOR OF TREATMENT CENTRE (or delegate) AUTHORISING LEAVE OF ABSENCE

Full Name *(Please print):*	Director ☐ Psychiatrist ☐ Authorised medical practitioner ☐ Delegate *(post consultation with director, psychiatrist or AMP* ☐
Signature	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print):*	

Office of the Chief Psychiatrist	Inquiries: (08) 8226 1091	Act Forms Fax: (08) 8115 5551
Internet: www.chiefpsychiatrist.sa.gov.au	Act Forms Email: HealthOCPMHLO@sa.gov.au	

LEAVE OF ABSENCE

(MRMHA-F)

1a Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

5. HEALTH SERVICE / AGENCY OBLIGATIONS

A copy of this form must be provided to the person before the leave commences.
A guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of this form (if appropriate), as soon as practicable.
A copy of Statement of Rights #5 must be provided to the person before the leave commences.
A copy of Statement of Rights #5 must be provided to a guardian, substitute decision maker (medical agent), relative, carer or friend of the patient if it is appropriate to do so.
The reasons for the making of this leave and the provision of copies must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

6. DIRECTOR OF TREATMENT CENTRE (or delegate) CANCELLATION OF LEAVE

☐ I hereby cancel this leave of absence in accordance with section 38 of the Act.

Reason for cancellation: .....

.....

.....

.....

Full Name *(Please print)*:	Director ☐ Psychiatrist ☐ Authorised medical practitioner ☐ Delegate *(post consultation with director, psychiatrist or AMP* ☐
Signature	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Health service/agency *(Please print)*:	

7. HEALTH SERVICE / AGENCY OBLIGATIONS

A copy of the cancellation must be provided to the person as soon as it is practicable.
A guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of the cancellation (if appropriate), as soon as practicable.